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MEMORANDUM

TO: Legislative Oversight Committee Members
Local CFAC Chairs
NC Council of Community Programs
County Managers
State Facility Directors
LME Board Chairs
Advocacy Organizations
MH/DD/SAS Stakeholder Organizations

Commission for MH/DD/SAS
State CFAC
NC Assoc. of County Commissioners
County Board Chairs
LME Directors
DHHS Division Directors
Provider Organizations
NC Assoc. of County DSS Directors

FROM: Tara Larson 
Leza Wainwright 

SUBJECT: Implementation Update #53
Revised POC Policy
Accreditation Clarification
Retro-Eligibility for In-Patient Services

CAP-MR/DD Update
Service Requests Available via ProviderConnect
LME UM Project

Revised Plan of Correction Policy Posted to the Web on January 2, 2009

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) issued a revised Plan of Correction (POC) Policy and Procedure on December 15, 2008. Although effective that date, it will be applied to new plans of correction required on or after the date the revised policy was posted, January 2, 2009. You will find the revised POC policy under "What's New?" on the Division's website at: www.ncdhhs.gov/mhddsas/whatsnew.htm

The Plan of Correction policy outlines the following criteria:

- Requirements of a POC
- Timelines for submission of a POC
- Review by either the Local Management Entity (LME) or MH/DD/SAS staff (Oversight Personnel)
- Requirements for accepting a POC
- Requirements for the approval of a POC
- Consequences for failure to submit the POC within timeframes
- Consequences for failure to implement the POC as written

Plans of Correction continue to be required for systemic issues discovered through audits, regular monitoring and/or investigations. The first major change to the POC policy involves the number of opportunities granted to a provider agency to respond to correspondence from the Oversight Personnel (either LME or DMH/DD/SAS staff) that has required the POC. The previous policy allowed a total of three notifications to a provider agency to submit a POC to Oversight Personnel. The revised policy requires the following:

- If a provider agency does not respond to notification that a POC is required within the designated time frame, the Oversight Personnel will send only one other notification for a total of two notifications to respond with a POC.

- If a POC has not been received by the Oversight Personnel within ten calendar days of the second and final notification, the process for withdrawal of endorsement by the LME, per Rule 10A NCAC 26C .0502. and/or the process to revoke the authority to bill public MH/DD/SAS funds, per “Protocol for Summary Suspension and Revocation to Receive Public Funding for Providing Mental Health, Developmental Disabilities and Substance Abuse Services” may occur.

A second change to the POC policy involves the number of opportunities to submit a POC acceptable to Oversight Personnel. It has been reduced from a total of three to a total of two:

- If a provider agency submits a POC that is not accepted by Oversight Personnel, the agency has only one additional opportunity to revise its POC to fulfill the requirements of an acceptable POC and submit it to Oversight Personnel.
- If the second and final submission of the POC is not accepted by Oversight Personnel, the process may begin to withdraw endorsement, per Rule 10A NCAC 26C .0502. and/or revoke the authority to bill public MH/DD/SAS funds, per “Protocol for Summary Suspension and Revocation to Receive Public Funding for Providing Mental Health, Developmental Disabilities and Substance Abuse Services.”

No change was made to the requirement that an agency was granted a total of two opportunities, i.e., one initial and one follow-up review by the Oversight Personnel, to implement and demonstrate that the systemic issues are remedied within 60 days of an acceptable POC submission.

Accreditation Clarification

One of the most important reasons that national accreditation was instituted as a requirement for providers of Medicaid services was to ensure that those provider organizations have a demonstrated infrastructure to provide such important components as ethical governance, financial accountability, human resources, quality management, and risk management. To this end, the Medicaid service definitions, and the CAP-MR/DD Waiver specify that it is the “provider organization” which is to be accredited within the identified timeline.

For accreditation agencies which require service-specific accreditations, the review against individual service standards is also important. However, if a provider selects an accreditation agency which performs service-specific accreditations, whenever a provider organization chooses to add a service, that organization would ordinarily have to seek out the service-specific accreditation for that service, and that would have to be done under the one-year benchmarks and timeline established by GS 122C-81, which went into effect last summer. While we do believe that those service specific reviews should take place, we believe that if a provider achieves compliance with the service specific standards during the period prior to the accreditation agency’s next regular review (usually within three years) that this timeline would be more reasonable and would satisfy the requirement of the service definition. We also believe that the LME’s responsibility to endorse a provider to offer specific services ensures that the provider has appropriate clinical and programmatic staff, and a working knowledge of the service. Therefore:

- If a provider agency has achieved national accreditation as an organization, it has satisfied the requirement of the enhanced service definition and/or the CAP-MR/DD waiver.
- If a provider is enrolled in the Medicaid program prior to July 1, 2008, that provider has, per the service definition, three years from the time of enrollment in the first service the provider enrolls, to achieve national accreditation.
- If a provider is enrolled in the Medicaid program subsequent to July 1, 2008, that provider has one year to meet the accreditation requirements.
- For those providers who choose to contract with an accreditation agency which accredits at the service-specific level (CARF or COA), once the provider organization is accredited within the appropriate timelines per the service definition and/or CAP-MR/DD waiver (whichever is more restrictive), should that provider choose to add other services which require national accreditation, those service-specific accreditation activities must occur within the normal accreditation cycle of the agency.
 - For example, if a provider is accredited for Community Support and achieves accreditation within the appropriate timelines, and that provider chooses to add CAP-MR/DD services, that provider has already met the CAP-MR/DD waiver requirement for being accredited within one year of enrollment.
 - Likewise, if the same Community Support agency which has achieved national accreditation chooses to add Intensive In-Home Services, that provider has already met the service definition requirement for national accreditation within either three years or one year of enrollment, as is applicable.

Revised Pending and Retro-Eligibility Guidelines for Inpatient and MH/DD/SA Services

In the July 2006 Special Bulletin, *Authorization and Utilization Review for Behavioral Health Services*, hospitals were given direction for obtaining both prior and concurrent medical necessity authorizations, depending on the status of Medicaid eligibility. In order to create a more consistent approach, the Division of Medical Assistance (DMA) is revising the prior authorization review procedures for individuals who are not active Medicaid recipients at the time of admission. The new procedures are as follows:

For individuals who have active, verifiable Medicaid coverage at the time of admission for psychiatric services, concurrent medical necessity will be reviewed by contacting ValueOptions as described in the July 2006 Special Bulletin. Note that this applies only to patients admitted with active full Medicaid coverage. Individuals with only family planning Medicaid coverage are not covered for mental health services.

For individuals who do not have verifiable, active Medicaid at the time of admission but who subsequently are approved for Medicaid covering the time of service, ValueOptions will provide a retrospective review of the service rendered. Although there is no longer a specific time limit for the submission of medical records to ValueOptions for their review, hospitals must make every effort to submit requests for retro-reviews within Medicaid's timely filing guidelines of 365 days from the date of discharge as described in 10A NCAC 22B.0104.

THESE CHANGES SHALL BE EFFECTIVE FOR ADMISSIONS OCCURRING ON OR AFTER FEBRUARY 1, 2009.

Retrospective reviews will entail the following process. Please note these guidelines for retro-eligibility determinations also apply to enhanced, outpatient and residential services that require authorization by Medicaid's utilizations management organization.

The hospital or provider must verify that the individual has been approved for Medicaid and submit the medical record documentation to ValueOptions after verification of Medicaid eligibility. Effective on February 1, 2009, hospitals and providers may submit medical records for retroactive Medicaid eligibility patients (including those admitted prior to February 1, 2009) to ValueOptions for review and issuance of authorization numbers. As noted above, the billing time limitations described in 10A NCAC 22B.0104 will still apply. ValueOptions will also conduct medical necessity review for patients who were approved for Medicaid during or after their admissions, and whose discharges occurred within the past year.

Regardless of the date of retroactive Medicaid approval, ValueOptions will determine whether the days or services were medically necessary and send notification of the review to the provider. Notification will occur within 60 days of record receipt.

For individuals subject to Certificate of Need (CON) review, DMA suggests that a CON should be performed regardless of Medicaid status on admission and retained in the medical record. Medicaid cannot accept a back dated CON.

A provider may request a reconsideration review of provider claims denials in accordance with 10A NCAC 22J.0102 and .0103. All other requirements for prior approval of inpatient services apply for Medicaid recipients.

CAP-MR/DD Update

Implementation of the Uniform Person Centered Plan (PCP) Format

As was indicated in the 11-05-08 CAP-MR/DD Update, the implementation of the uniform PCP format was *intended* to begin with plans due to ValueOptions March 1, 2009 (plans for April birthdays). Since then, the implementation of the uniform PCP format has been delayed. For any provider who has in good faith begun the use of the new PCP format there is no need to redo these plans on the old Plan of Care format. Otherwise, case managers should wait for further notice from the DMH/DD/SAS to use the new PCP format. This notice should occur very soon and should not adversely delay the submission of plans to ValueOptions. Although, if a Plan of Care is due to be completed/submitted to ValueOptions prior to further notice by the DMH/DD/SAS the case manager should use the Plan of Care format. For further information related to this matter review the information on our website, www.ncdhhs.gov/mhddsas/.

Billing of Supplies

A provider's usual and customary charge for a supply or the amount a provider actually pays for a supply may be different than the maximum allowable amount posted on the current Medicaid fee schedule. **For Example:** If a Provider/LME bills \$.97 for diapers and the current Medicaid maximum allowable is \$.90 the amount paid is \$.90, which is the Medicaid maximum allowable. The LME should accept the providers' invoice with this cost even if it may be different than the maximum allowable amount posted on the current fee schedule. Medicaid will reimburse the LME the lower of the two, the provider's usual and customary charge or the maximum allowable by Medicaid. The LME is only responsible for paying the provider the amount received from Medicaid.

More Services Available for Submission of Online Requests via ProviderConnect

Providers may now submit service requests for Medicaid consumers to ValueOptions via ProviderConnect for the following levels of care:

- Assertive Community Treatment Team (ACTT)
- Community Support (CS)
- Community Support Team (CST)
- Child and Adolescent Day Treatment
- Facility Based Crisis
- Intensive In-Home (IIH)
- Multisystemic Therapy (MST)
- Psychosocial Rehabilitation (PSR)
- Opioid Treatment
- Substance Abuse Intensive Outpatient (SAIOP)
- Substance Abuse Comprehensive Outpatient (SACOT)
- Substance Abuse Non-Medical Community Residential
- Substance Abuse Medically Monitored Community Residential
- Ambulatory Detoxification
- Non-Hospital Medical Detoxification
- ADATC

In addition, *concurrent* requests for residential services, Level I-IV and Therapeutic Foster Care (TFC), may now be submitted via ProviderConnect. Make certain to select “Residential Child Care” as the level of care for Level I-IV and “Foster Care” for TFC requests. *Initial* requests for residential and TFC should continue to be submitted via fax. Please note that because TFC providers are not direct enrolled and do not have a provider number, concurrent TFC requests are submitted by the clinical home qualified professional using the clinical home provider number; in turn ValueOptions will make the authorization to the appropriate LME.

Providers must participate in webinar training before using ProviderConnect to submit service requests. Go to http://www.valueoptions.com/providers/Network/North_Carolina_Medicaid.htm and scroll down to “Provider Training Opportunities” to view the webinar schedule and register. Providers who previously completed webinar training for submitting Community Support requests need not attend again as the only change to online request submission is selection of the appropriate Level of Care from the drop-down menu.

LME Utilization Management (UM) Project

The North Carolina General Assembly House Bill 2436 Section 10.15 (x) requires the Department of Health and Human Services return the service authorizations, utilization reviews, and utilization management (UM) functions to the Local Management Entities. By July 1, 2009, utilization review, utilization management, and service authorization for publicly funded mental health, developmental disabilities, and substance abuse services must be performed by LMEs representing in total at least thirty percent of the State’s population.

In response to this mandate, a project team was created with representation from the Division of Medical Assistance and the Division of MH/DD/SAS. In November, all LMEs were sent a proposal package which included instructions for submitting a proposal, the requirements and procedures document, and a response document. A question and answer session was held and proposals from interested LMEs were received in December.

An evaluation committee was created which reviewed and scored the proposals received. In addition, site visits were conducted. We are pleased to announce that four LMEs have been selected: The Durham Center, Eastpointe, Mecklenburg Area MH/DD/SAS Authority and Western Highlands Network. Implementation of Medicaid utilization management with the four selected LMEs is targeted to begin July 1, 2009. Additional information on how this transfer will take place will be forthcoming.

Unless noted otherwise, please email any questions related to this Implementation Update to ContactDMH@ncmail.net.

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